CERTIFICATE OF PATIENT STATUS

City/County
(Circle One)

		Birthdate	VMAP Office Use
Facility	Medicaid No.		Excep. Ind.
N. H. Adm. Date	Med. Elig. Date	Provider No.	Review Date
Admitted From		Medicare No.	Control No.
Authorization Date			

Primary Diagnosis — Secondary Diagnosis

Other Diagnosis

Recent Hospitalizations/Dates

Reason for Hospitalization

Mobility:
- Completely Bedridden
- Up in chair
- Ambulates with help of
- person/device
- Independent Ambulation

Feeding:
- Special diet
- Naso-gastric-tube
- Needs to be fed
- Feeds self

Elimination:
- Catheter
- Ileostomy/colostomy
- Incontinent
- Continent

Mental Status and Behavior:
- Confused
- degree
- Alert and oriented
- Aberrant
- Memory and judgment

Self-Help Skills:
- Describe

Medications:

Name	Dosage	Frequency

Special Treatments:

Special Needs/Comments:

Special Disabilities:
- Aphasia
- Decubitus (area, severity)
- Amputation (area)
- Paralysis (area)
- Vision/Hearing
- Comments:

Restorative Services:
- Prosthesis
- Bowel/Bladder Training
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Diagnostics
- Self-Help Training

This patient requires:

_____ Skilled Nursing Care
_____ Intermediate Nursing Care
_____ Nursing Care Not Indicated

Date _____ _____, M.D. Date _____ _____
Admitting Physician Administrator

FOR STATE HEALTH DEPARTMENT USE ONLY

Approved for Skilled Nursing Services _____ Intermediate Nursing Services _____
Nursing Care Not Indicated _____

Need for Continued Nursing Home Care To Be Reviewed Within _____ Months.

DMAS - 121 R7/78

Review Officer _____ Date _____